LUCTON SCHOOL

MEDICAL RECORD

Pupil Full Name	
Date of Birth	

This medical record booklet must be completed in full and the declaration signed and returned before the pupil starts school

DECLARATION		
I agree to the following information being kept by Lucton School. ✓ *I hereby give permission for authorised school staff to take whatever action they may consider necessary for the immediate health and/or safety of my son/daughter in the event of a serious illness or injury.* ✓ *I also give permission for authorised school staff to administer paracetamol tablets or other simple medicines when judged to be absolutely necessary.* ✓ *I also give permission for authorised staff to administer first aid when necessary.*		
Pupil Name (PRINT)		
PARENT DETAILS	**PARENT / GUARDIAN 1**	**PARENT / GUARDIAN 2**
Parent Name (PRINT)		
Parent Signature		
Relationship to Pupil		
Home Address		
Post Code		
Home Telephone		
Mobile Telephone		
Work Phone		
Email Address		

EMERGENCY CONTACT			
Please give details below who you would like to be contacted should there be an EMERGENCY and the school is unable to contact either of the above.			
Name		**Relationship to Pupil**	
Address			
Home Telephone		**Mobile Phone**	
Work Phone		**Email**	

BASIC HEALTH INFORMATION				
DOCTOR	National Health Number (UK pupils)			
	Name of Doctor			
	Address of Doctor			
	Postcode		Telephone	
DENTIST	Does the pupil wear a brace?			
	If Yes, please give details.			
	Name of Dentist			
	Address of Dentist			
	Postcode		Telephone	
OPTRICIAN	Does the pupil wear glasses?			
	If Yes, should they be worn at school?			
	Name of Optician			
	Address of Optician			
	Postcode		Telephone	
AUDIOLOGIST	Does the pupil have hearing problems?			
	If Yes, please give details			
	Name of Audiologist			
	Address of Audiologist			
	Postcode		Telephone	

MEDICAL CONDITIONS				
ASTHMA	Does the pupil suffer from Asthma?			
	Name of Consultant			
	Triggers/Details			
	Medication			
	Dose		Frequency	
HAYFEVER	Does the pupil suffer from Hayfever?			
	Triggers/Details			
	Medication			
	Dose		Frequency	
ALLERGIES	Is the pupil allergic to any Medication?			
	If Yes, please give details			
	Does your child suffer from any Allergies, excluding food?			
	If Yes, please give details			
	Does the pupil suffer from any Food Allergies?			
	If Yes, please give details			
OTHER AILMENTS	Does the pupil suffer from any other Ailments?			
	If Yes, please give details			
	Triggers/Details			
	Medication			
	Dose		Frequency	

ADDITIONAL INFORMATION		
Has the pupil lived overseas?		
If Yes, please give full details		
Has the pupil had any operations?		
If Yes, please give details including dates		
ADDITIONAL SUPPORT	**Does the pupil have an Educational Psychologist's report?**	
	If Yes, please give details	
	Does the pupil have a learning support plan?	
	If Yes, please give details	
	Does the pupil have any social, emotional, behavioural problems?	
	If Yes, please give details	
	Boarding pupils only Does the pupil wet the bed?	
	If yes, please give details	

ILLNESSES		
Has the pupil had any of the following? If Yes, please provide details and dates.		
Chicken Pox	◯ YES ◯ NO *	
Rubella (German Measles)	◯ YES ◯ NO *	
Measles	◯ YES ◯ NO *	
Mumps	◯ YES ◯ NO *	
Whooping Cough	◯ YES ◯ NO *	
Any tropical disease?	◯ YES ◯ NO *	
Covid-19	◯ YES ◯ NO *	
Any other disease?	◯ YES ◯ NO *	

IMMUNISATION RECORD		
Please complete the following in as much detail as possible. Please do supply further information you feel would be of benefit using additional paper.		
When to Immunise	**Disease Protected against**	**Date of Immunisation**
Two months old	☐ Diphtheria, tetanus, pertussis (whooping cough) ☐ Polio and *Haemophilus influenzae* type b (Hib) ☐ Pneumococcal infection (13 serotypes) ☐ Meningococcal group B (MenB)[1] ☐ Rotavirus gastroenteritis	
Three months old	☐ Diphtheria, tetanus, pertussis, polio and Hib ☐ Meningococcal group C disease (MenC) ☐ Rotavirus	
Four months old	☐ Diphtheria, tetanus, pertussis, polio and Hib ☐ Pneumococcal (13 serotypes ☐ MenB[1]	
Twelve months old	☐ Hb and MenC ☐ Pneumococcal ☐ Measles, mumps and rubella (German measles) ☐ MenB[1]	
Two to six years old (including children in school years 1 and 2)	☐ Influenza (each year from September)	
Three years four months old or soon after	☐ Diptheria, tetanus, pertussiss and polio ☐ Measles, mumps and rubella	
Girls aged 12 to 13 years	☐ Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)	
Twelve plus	☐ Covid-19	
Fourteen years old (school year 9)	☐ Tetanus, diphtheria and polio ☐ Meningococcal groups A, C, W and Y disease	
Any other Vaccinations (if applicable)		
ADDITIONAL INFORMATION		
Please provide any further medical information about your child on an additional sheet.		